MENTAL HEALTH PLANNING COUNCIL
MEETING April 16, 2008
MINUTES

The 4/16/2008 meeting of the Mental Health Planning Council was called to order by the president, Alison Hymes at 10:05 am. The meeting began with introductions around the table. The following members, staff and guests were present:

Members

Pierre Ames

Ann Benner

Jack Brandt

Ann Cutshall

Betty Etzler

Rick L. Feldman

Dawn Girard

Catherine Hancock

Vicki Hardy-Murrell

Melissa C. Harless

Donna-Sue M. Harmon

Alison Hymes

James A. Johnson

Mary Kaye Johnston

James M. Martinez

Mary McQuown

Kenneth Moore

Lisa Moore

Brian Parrish

Paula Price

Mira Signer

Becky Sterling

Byron Stith

Tracey Jackson for Vernon Simmons

Staff

Will Ferriss

Janet Lung

Michael Shank

Jo-Amrah McElroy

George Banks

Guests

Michael J. Carrasco

Sherry Rose

Chris Owens

Candace Benn

Nick Hornick

Bonnie Neighbor

Katherine Hunter

Jeanette Duval

Julie Triplett

Dr. James Morris

The following members did not attend:

Patrice Beard

Patricia Fowler

Robin L. Hulbert

Paige McCleary

Steven F. Peed

Kathleen Sadler

Joe Speidel

Irene Walker-Bolton

Tom Weaver

Heather Wiltberger

Jack Wood

Ann Benner reminded everyone of the VOCAL conference coming up on May 20-22 at James Madison University.

Jim Martinez provided everyone with a copy of Governor Kaine's comments on mental health bills. The budget changes are not finalized yet but they are meant to take care of the new legislation. There will be a need for

training to implement the new laws and to see that they are applied consistently. DMHMRSAS is working on a web site to educate people on the new laws. The laws passed regarding involuntary commitment have lowered the standard applied, not just clarified and standardized them.

There is $750 thousand in block grant funds for consumer run programs. DMMRSAS is still working on a process to award the funds to programs. The money should be available July 1, 2008.

Unspent money from 07-08 fiscal year will be used by programs already in place. There was a request made that DMHMRSAS send out details on how this money is spent. Jim said that would be done. Contracts have to be in a 12-month period. Programs will not have to go through Community Service Boards. There need to be discussions on accountability for those providing consumer services. Concern was voiced over fees charged for distributing money.

The question was raised as to how much money has been spent and how many people have taken Peer Support Training. Jim says that an exact number on dollars spent can be supplied. There was a further question about this program applying to adolescents. Currently the program is open to all 18 or older.

Our next speaker was Julie Triplett from VOPA. She spoke on the subject of SSDI and work incentives.

There are two programs that need to be differentiated when talking about SSDI. There is also SSI. SSI is Supplemental Security Income. This is a needs based program. If the need is based on a disability, Social Security must have

determined that there is a disability before SSI will apply there are two criteria for receiving SSDI. You must be disabled and have had paid into the Social Security Disability Insurance fund.

In applying for SSI you are limited as to the resources you may have. These resources are defined and do not include you home, your car and some forms of life insurance.

A person can collect both SSI and SSDI or keep the higher of the two. Medicaid applies to SSI. Medicare applies to SSDI.

Discussion on time period under which you can apply for SSDI brought out that it is not well known that there is a time limit to apply. You must have worked recently in order to be eligible even if you worked for many years in the past. Your disability has to be expected to last at least a year to be eligible for SSDI and SSI.

There was discussion (and a handout provided) on limits for how much a person on SSDI can earn. The most important thing is that all earnings be reported and documented. Income allowed can be offset by work related expenses due to the disability. Again, document and report.

All information must be reported to Social Security on a monthly basis. This is important because if you earn more than you are allowed you can lose all of your disability payments.

Persons receiving SSI can make up to $84 a month. If you earn more and do not qualify, you can still receive Medicaid earning up to $29,348. Beyond this, you can buy into Medicaid.

How does inheritance affect SSI? It depends on if it is in cash or a trust.

There are Community Work Incentive Coordinators who can advise you on how you can work and still keep your benefits. A handout was provided on those in Virginia as well at the state Social Security Offices. The speaker referred to workworld.org for help navigating these programs.

A break was taken for lunch. At noon, there was a moment of silence to remember the victims of the 4/16/07 shooting at Virginia Teach.

Alison called the meeting back to order. She noted that the next meeting of the Adult Services Committee of the Council would be May 2 in Charlottesville at the Department of Forestry.

There is a critical need for a chairman for the Membership Committee. There was discussion of ratios required on the council, especially parents of children with serious emotional disorders. Janet Lung explained that the needs of children under 18 have to be represented on the Council by federal regulations but that does not have to be entirely by parents of children currently under 18.

Jim Morris, Ph.D. of DMHMRSAS spoke regarding anxiety disorders and Post Traumatic Stress Disorder (PTSD). PTSD is listed under anxiety disorders in the Diagnostic and Statistical Manual of the APA.

Anxiety – fear without an apparent reason

Generalized Panic Disorder- recurring fears or worries, sense that something bad is going to happen.

Panic Disorder – sudden, intense and unprovoked feeling of terror and dread

Phobias: intense fears about certain objects or situations

Compulsive Obsessive Disorder – irrational fears, rituals, unwanted thoughts

PTSD – reminders of physical or emotional trauma affect thoughts, feelings and behaviors months or years after incident

Symptoms of shortness of breath, racing heartbeat, trembling and dizziness. Genetic predisposition in certain anxiety disorders.

Psychotherapy is the only effective treatment for PTSD. Medication may be used for symptom control but does not lead to recovery.

DSM-IV criteria for PTSD are:

Exposure to a traumatic event in which the person experienced, witnessed or was confronted by death or serious injury to self or others AND responded with intense fear, helplessness or horror

Symptoms appear in 3 symptom clusters: re-experiencing, avoiding/numbing and hyper-arousal.

There is a wide spectrum of traumas that may cause PTSD including exposure to intense emotional conflict in a child's home or living in a fearful environment as a child such as a neighborhood with a lot of violence. Traumas informed care realizes there are long-term affects of past events.

PTSD is "normal" on the battlefield but makes it hard for soldiers returning home with no transition period. Having cell phones on the battlefield

can further blur the lines of what is real. The nebulousness of the enemy makes adjustment difficult. Spirituality, ethics and morals can affect how we deal with war.

There is little historical data on women in combat. Problems are apparent in domestic settings where other family members do not seem to understand or care about what the person living with PTSD is feeling.

Mental health professionals have to learn to address the past abuse and not just the current symptoms or behavior produced by it. Many are now knowledgeable but not skilled.

Many people without combat experience in our state mental health system have PTSD. The question was raised how our present system of care does or does not meet their needs. For example, the difficulty accessing long-term psychotherapy at Community Service Boards is an issue.

George Banks spoke on National Outcome Measures. We need to define who needs mental health services not just those receiving them. Collecting data is currently done through CSB's and is from people already classified as mentally ill. George encouraged member to let Alison know what types of data they would like to see so George can use that information.

Alison raised the issue of revising our bylaws to eliminate inactive committees. She will send out changes at least 2 weeks prior to our next meeting. That meeting will be on 6/18 at the Henrico CSB.